

**12VAC30-120-140. Definitions.**

The following words and terms, when used in this part, shall have the following meanings, unless the context clearly indicates otherwise:

~~"Activities of daily living" means assistance with personal care tasks (i.e., bathing, dressing, toileting, etc.).~~

"Acquired Immune Deficiency Syndrome" or "AIDS" means the most severe manifestation of infection with the Human Immunodeficiency Virus (HIV). The Centers for Disease Control and Prevention (CDC) lists numerous opportunistic infections and cancers that, in the presence of HIV infection, constitute an AIDS diagnosis.

~~"Acquired immunodeficiency syndrome (AIDS)" means the set of symptoms related to specific opportunistic diseases indicative of an immune deficiency state in the absence of any other cause of reduced resistance reported to be associated with at least one of those opportunistic diseases. Individuals diagnosed with AIDS may experience symptoms associated with severe dementia, HIV encephalopathy, HIV wasting syndrome and rare forms of pneumonia (pneumocystis carinii (PCP)) and cancer (Kaposi's Sarcoma (KS)).~~

"Activities of daily living" or "ADL" means personal care tasks, ~~i.e., e.g.~~, bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and ~~services.~~ service needs.

~~"AIDS Related Complex" or ("ARC)" means the lesser disease response to the HIV infection which may, nonetheless, have many of the devastating effects of the AIDS virus, but not the specific conditions used to define a case of AIDS. This term shall be applied to those individuals with HIV infection experiencing symptoms related to the infection.~~

~~"AidsAIDS Service Organizations" or ("ASOs)" means the regional and local service organizations developed to provide education, prevention, and health and social services to individuals infected with the HIV virus.~~

"Appeal" means the process used to challenge adverse actions regarding denial or reduction of services, benefits, and reimbursement provided by Medicaid pursuant to 12 VAC30-110-10 et seq. and 12 VAC30-20-500 through 30-20-560.

"Asymptomatic" means without symptoms. This term is usually used in the HIV/AIDS literature to describe an individual who has a positive reaction to one of several tests for HIV antibodies but who shows no clinical symptoms of the disease.

"Case management" means continuous reevaluation of need, monitoring of service delivery, revisions to the ~~Plan of Care~~ plan of care and coordination of services for AIDS individuals receiving home and community-based services in order to assure effective and efficient delivery of direct services.

~~"Case manager" means the professional person who provides services to recipients which enables the continuous assessment, coordination, and monitoring of the needs of the individuals diagnosed with AIDS or ARC throughout the term of the individuals' receipt of waiver services. The case manager must possess~~ individual who provides services to recipients that enable the continuous assessment, coordination, and monitoring of the needs of the recipient diagnosed with HIV or AIDS. The case manager must possess a combination of work experience and relevant education that indicates that the case manager possesses the knowledge, skills, and abilities at entry level, as established by the Department of Medical Assistance Services in ~~12VAC30-120-160~~ 12 VAC30-120-170 to conduct case management.

"Cognitive impairment" means a severe deficit in mental capability that affects areas such as thought processes, problem-solving, judgment, memory, or comprehension, and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.

"Consumer-directed services" means services for which the recipient or family/caregiver is responsible for hiring, training, supervising, and firing of the staff.

"Consumer-directed (CD) services facilitator" means the DMAS-enrolled provider who is responsible for supporting the recipient and family/caregiver by ensuring the development and monitoring of the consumer-directed plan of care, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed personal assistance and respite care services.

"Current functional status" means the recipient's ~~individual's~~ degree of dependency in performing activities of daily living.

"DMAS" means the Department of Medical Assistance Services.

"DMAS-122 form" means the Patient Information Form, which is used by the provider and the local DSS to exchange information regarding the responsibility of a Medicaid-eligible recipient to make payment toward the cost of services or other information that may affect the eligibility status of a recipient.

"DSS" means the Department of Social Services.

"Designated preauthorization contractor" means the entity that has been contracted by DMAS to perform preauthorization of services.

"Enteral nutrition" means nonlegend drug enteral nutrition covered under this waiver that is deemed by a physician, to be necessary as the primary source of nutrition for the recipient's health care plan (due to the prevalence of conditions of wasting, malnutrition, and dehydration) and not available through any other food program.

~~"Episodic respite care" means in-home services specifically designed to provide relief to the caregiver for a non-routine, short-term period of time for a specified reason (e.g., respite care offered for 7 days, 24 hours a day while the caregiver takes a vacation).~~

"Fiscal agent" means an agency or organization that may be contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of the recipient who is receiving consumer-directed personal assistance services and consumer-directed respite services.

"Home and community-based care" means a variety of in-home and community-based services reimbursed by DMAS (case management, personal care, ~~skilled-private duty nursing~~, respite care, consumer-directed personal assistance, consumer-directed respite care, and enteral nutrition~~nutritional supplements~~) authorized under a Social Security Act §1915(c) AIDS Waiver designed to offer individuals an alternative to inpatient hospital or nursing facility ~~care~~ placement. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or ~~service(s)~~ services in order to avoid inpatient hospital or nursing facility ~~or inpatient hospital~~ placement. ~~An individual may only receive home and community-based services up to the amount which would be equal to or less than the cost of hospital or nursing facility care.~~

DEPT. OF MEDICAL ASSISTANCE SERVICES

HIV/AIDS Waiver Services

12 VAC 30-120-140 et. seq.

Page 3 of 42

~~The Nursing Home preadmission screening team, or~~ DMAS, or the designated preauthorization contractor shall give prior authorization for any Medicaid-reimbursed home and community-based care.

"Human Immunodeficiency Virus" or ("HIV") means the virus which leads to acquired immune deficiency syndrome (AIDS). The virus weakens the body's immune system and, in doing so, allows "opportunistic" infections and diseases to attack the body.

"Instrumental activities of daily living" or "IADL" means ~~social tasks such as ,i.e.,~~ meal preparation, shopping, housekeeping, laundry, and money management. ~~An individual's degree of independence in performing these activities is part of determining appropriate level of care and services. Meal preparation is planning, preparing, cooking, and serving food. Shopping is getting to and from the store, obtaining and paying for groceries, and carrying them home. Housekeeping is dusting, washing dishes, making beds, vacuuming, cleaning floors, and cleaning the bathroom and kitchen. Laundry is washing and drying clothes. Money management is paying bills, writing checks, handling cash transactions, and making change.~~

~~"Nursing Home Preadmission Screening" or "NHPAS PAS" means the process to (i) evaluate the functional, nursing, and social supports needs of individuals referred for preadmission screening, (ii) analyze what specific services the individuals need, and (iii) evaluate whether a service or a combination of existing community services are available to meet the individuals' needs, and (iv) authorize Medicaid-funded nursing facility or community-based care for those individuals who meet nursing facility level of care.~~

~~"Nursing Home Preadmission Screening Committee/Team" or "NHPAS PAS Committee" or "NHPAS PAS Team" means the entity contracted with DMAS that is responsible for performing nursing home preadmission screening. For individuals in the community, this entity is a committee comprised of a nurse from the local health department and a social worker from the local department of social services. For individuals in an acute care facility who require preadmission screening, the this entity is a team of nursing and social work staff. A physician must be a member of both the local committee and an the acute care team.~~

~~"Nutritional supplements" means nonlegend drug nutritional supplements covered under this waiver which are deemed by a physician to be necessary as the primary source of nutrition for the AIDS/ARC recipient's individual's health care plan (due to the prevalence of conditions of wasting, malnutrition and dehydration) and not available through any other food program.~~

~~"Preadmission screening" means the process to: (i) evaluate the medical, nursing, and social needs of individuals referred for prescreening, (ii) analyze what specific services the individuals need, (iii) evaluate whether a service or a combination of existing community services are available to meet the individuals' needs, and (iv) authorize Medicaid-funded community-based care for those individuals who meet hospital or nursing facility level of care and require such care.~~

~~"Preadmission screening team" means the multidisciplinary team contracted with DMAS to perform preadmission screening. DMAS will contract with regional and local AIDS Service Organizations (ASO) to perform the prescreening assessment, level of care determination and Plan of Care development for Medicaid-eligible individuals with AIDS/ARC. Preadmission screening teams for individuals with AIDS/ARC may also be the nursing home preadmission screening teams contracted with DMAS to perform preadmission screening for Medicaid-eligible individuals at risk of placement in a nursing facility. At a minimum, the preadmission screening team must be comprised of the recipient, nursing and social work staff and a physician.~~

DEPT. OF MEDICAL ASSISTANCE SERVICES

HIV/AIDS Waiver Services

12 VAC 30-120-140 et. seq.

Page 4 of 42

"Participating provider" means an ~~entity~~ institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by DMAS and has a current, signed provider participation agreement with DMAS to provide Medicaid waiver services.

"Personal assistant" means ~~a person who provides personal assistance services.~~ for purposes of this part and exemption from Worker's Compensation, a domestic servant.

"Personal assistance services" or "PAS" means ~~assistance with Activities of Daily Living, Instrumental Activities of Daily Living, access to the community, monitoring of self-administration of medication or other medical needs, and the monitoring of health status and physical condition.~~ long-term maintenance or support services necessary to enable a recipient to remain at or return home rather than enter an inpatient hospital or a nursing facility. Personal assistance services include care specific to the needs of a medically stable, physically disabled recipient. Personal assistance services include assistance with ADLs, bowel/bladder programs, range of motion exercises, routine wound care which does not include sterile technique, and external catheter care. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical function. When specified supportive services may include assistance with IADLs which are incidental to the care furnished, or which are essential to the health and welfare of the recipient. Personal assistance services shall not include either practical or professional nursing services as defined in Chapters 30 and 34 of Title 54.1 of the Code of Virginia, as appropriate.

"Program" means ~~medical assistance services as administered by the Department of Medical Assistance Services.~~

"Participating provider" means ~~an institution, facility, agency, partnership, corporation, or association that has a valid contract with DMAS and meets the standards and requirements set forth by DMAS.~~

"Personal care services" means ~~long-term maintenance or support services necessary to enable the individual to remain at or return home rather than enter a nursing facility.~~ Personal care services include assistance with personal hygiene, nutritional support, and the environmental maintenance necessary for recipients to remain in their homes.

"Personal care agency" means a participating provider that renders services designed to offer an alternative to institutionalization by providing eligible recipients with personal care aides who provide personal care services.

"Personal care services" means long-term maintenance or support services necessary to enable the recipient to remain at or return home rather than enter an inpatient hospital or a nursing facility. Personal care services are provided to individuals in the areas of activities of daily living, instrumental activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, and the monitoring of health status and physical condition. It may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.

"Plan of Care" means ~~the written plan of services certified by the screening team physician as needed by the individual to ensure optimal health and safety for the delivery of home and community-based care.~~ developed by the provider related solely to the specific services required by the recipient to ensure for the delivery of home and community-based care developed by the provider and related solely to the specific services required by the recipient to ensure his optimal health and safety for the delivery of home and community-based care.

"Private duty nursing" means individual and continuous nursing care provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse.

"Program" means the Virginia Medicaid program as administered by the Department of Medical Assistance Services.

"Reconsideration" means the supervisory review of information submitted to DMAS or the designated preauthorization contractor in the event of a disagreement of a decision, that is made at an analyst's level, that is related to a denial in the reimbursement of services already rendered by a provider.

"Respite care" means ~~in-home services~~ specifically designed to provide a temporary, but periodic or routine relief, to the primary unpaid caregiver of ~~an individual~~ a recipient who is incapacitated or dependent due to AIDS. Respite care services include assistance with personal hygiene, nutritional support, and environmental maintenance authorized as either episodic, temporary relief, or as a routine periodic relief of the caregiver.

"Respite care agency" means a participating provider that renders services designed to prevent or reduce inappropriate institutional care by providing eligible recipients with respite care aides who provide respite care services.

~~"Routine respite care" means in-home services specifically designed to provide relief from continuous care to the caregiver on a periodic basis over an extended period of time (i.e., respite care offered regularly one day a week for six hours).~~

"Service facilitation provider" means the provider contracted by DMAS, for those individuals receiving consumer directed services, that who is responsible for ensuring that the assessment, development, and monitoring of the plan of care, management training, and review activities as required by DMAS are accomplished. ~~Individuals employed by the service~~ Service facilitation provider providers shall meet the knowledge, skills, and abilities as further defined in this part.

"Service plan" means the written plan of services certified by the ~~NHPAS~~ PAS team physician as needed by the individual to ensure optimal health and safety for the delivery of home and community-based care.

~~"Skilled nursing" means professional nursing care provided by a registered nurse or licensed practical nurse in the individual's home or other community setting that is and necessary to avoid institutionalization of the individual with AIDS. This service includes by assessment and monitoring of the medical condition, providing interventions, and communicating with the physician regarding changes in the patient's status.~~

"State Plan for Medical Assistance" or "the Plan" or "the State Plan" means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

~~"Uniform Assessment Instrument" or "UAI" means the standardized multidimensional questionnaire, which that assesses an individual's social, physical health, mental health, and functional abilities. The UAI is used to gather information for the determination of an individual's care needs and service eligibility, and for planning and monitoring an individual's care across various agencies for long-term care services.~~

**12VAC30-120-150. General coverage and requirements for home and community-based care services for individuals living with AIDS-HIV/AIDS.**

A. Coverage statement.

DEPT. OF MEDICAL ASSISTANCE SERVICES

HIV/AIDS Waiver Services

12 VAC 30-120-140 et. seq.

Page 6 of 42

1. Coverage shall be provided under the administration of ~~the Department of Medical Assistance Services~~ DMAS for individuals with HIV infection, who have been diagnosed and are experiencing the symptoms associated with AIDS, ~~or ARC~~, who would otherwise require the level of care provided in ~~a~~ an inpatient hospital or nursing facility.

2. These services shall be medically appropriate, ~~cost-effective~~ and necessary to maintain these individuals in the community.

B. Patient eligibility requirements.

1. DMAS will apply the financial eligibility criteria contained in the State Plan for the categorically needy and the medically needy. Virginia has elected to cover the optional categorically needy group under 42 CFR 435.211, 435.231 and 435.217. The income level used for 435.211, 435.231 and 435.217 is 300% of the current Supplemental Security Income payment standard for one person. Under this waiver, the coverage groups authorized under §1902(a)(10)(A)(ii)(VI) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. The medically needy individuals participating in the waiver will also be considered as if they were institutionalized for the purpose of applying the institutional deeming rules.

2. Virginia will reduce its payment for home and community-based ~~service~~ services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents and medical needs have been made, according to the guidelines in 42 CFR 435.735 and §1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS will reduce its payment for home and community-based services provided to an individual eligible for home and community-based waiver services by the amount that remains after deducting the following amounts in the following order from the individual's income:

a. For individuals to whom §1924(d) applies:

(1) An amount for the maintenance needs of the individual ~~which~~ that is equal to 300% of the categorically needy income standard for a noninstitutionalized individual.

(2) For an individual with only a spouse living at home, the community spousal income allowance determined in accordance with §1924(d) of the Social Security Act, the same as that applied for the institutionalized patient.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family determined in accordance with §1924(d) of the Social Security Act, the same as that applied for the institutionalized patient.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:

(a) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(b) Necessary medical or remedial care recognized under state law, but not covered under the state's Medicaid Plan.

b. For all other individuals:

- (1) An amount for the maintenance needs of the individual ~~which~~ that is equal to 300% of the categorically needy income standard for a noninstitutionalized individual.
- (2) For an individual with a family at home, an additional amount for the maintenance needs of the family ~~which~~ that shall be equal to the medically needy income standard for a family of the same size.
- (3) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:
  - (a) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and
  - (b) Necessary medical or remedial care recognized under state law, but not covered under the state's Medicaid Plan.

C. Assessment and authorization of home and community-based care services for individuals living with AIDS/~~ARC~~.

~~1. The individual's status as an AIDS/ARC individual in need of home and community-based care services shall be determined by the preadmission screening team after completion of a thorough assessment of the individual's needs and available support. Screening by the preadmission screening team and preauthorization of home and community-based care services by DMAS staff, or the designated preauthorization contractor is mandatory before Medicaid will assume payment responsibility of home and community-based care services.~~

1. To ensure that Virginia's home and community-based care waiver programs serve only individuals who would otherwise be placed in an inpatient hospital or nursing facility, home and community-based care services shall be considered only for individuals who meet DMAS' inpatient hospital or nursing facility criteria, are seeking nursing facility admission, or for individuals who are at imminent risk of nursing facility admission. "Imminent risk" is defined as within one month. Home and community-based care services shall be the critical service that enables the individual to remain at home rather than being placed in an inpatient hospital or nursing facility.

2. The recipient's eligibility for home and community-based care services shall be determined by the Preadmission Screening Team after completion of a thorough assessment of the recipient's needs and available supports. If a recipient meets nursing facility or inpatient hospital criteria, the PAS Team shall give the recipient the choice of receiving community-based care or care in a nursing facility. In order to meet inpatient hospital criteria the recipient must have had an inpatient hospital admission within three months of the request for waiver services for an AIDS-related reason.

3. Before Medicaid will assume payment responsibility of home and community-based care services, preauthorization must be obtained from the designated preauthorization contractor on all services requiring preauthorization. Providers must submit the required information to the designated preauthorization contractor within ten business days of initiating care. If the provider submits the required information to the designated preauthorization contractor within ten business days of initiating care, authorization of the services may begin with the date the provider initiated services but not preceding the date of the physician's signature on the Medicaid Funded Long-Term Care Service Authorization Form (DMAS-96). If the provider does not submit the required information to the designated preauthorization contractor within ten business days of initiating care, authorization of the services may begin with the date the information was received by the designated preauthorization contractor.

DEPT. OF MEDICAL ASSISTANCE SERVICES

HIV/AIDS Waiver Services

12 VAC 30-120-140 et. seq.

Page 8 of 42

~~2. An essential part of the preadmission screening team's assessment process is determining the level of care required by applying existing criteria for hospital or nursing facility care according to the Virginia Medicaid Hospital Criteria or the Virginia Medicaid Nursing Facility Criteria.~~

~~3.4. The PAS Team team shall explore alternative settings and/or services to provide the care needed by the individual. If nursing facility hospital placement or a combination of other services are determined to be appropriate, the screening team shall initiate referrals for service. If Medicaid funded home and community-based care services are determined to be the critical service to delay or avoid nursing facility or inpatient hospital hospital or nursing facility placement, the screening team shall develop an appropriate Plan of Care, service plan and initiate referrals for service. compute cost effectiveness and make a recommendation for waiver services.~~

~~4.5. The individual may be determined eligible to receive Virginia's home and community-based care services for individuals with AIDS /ARC may only be recommended by the preadmission screening team if:~~

~~a. The physician who is part of the designated preadmission screening team specifically states the individual has a diagnosis of AIDS; or ARC;~~

~~b. The preadmission screening team can document that the individual is experiencing medical and functional symptoms associated with AIDS or ARC which would, in the absence of waiver services, require the level of care provided in a hospital, or a nursing facility, the cost of which would be reimbursed under the State Medicaid Plan. Persons who would revert to a nursing facility level of care without continuation of waiver services will be allowed to continue to participate in the waiver.~~

~~c. The individual requesting waiver services is not an inpatient of a nursing facility or hospital,~~

~~d. Waiver services can reasonably be expected to cost equal to or less than institutional services and ensure the individual's safety and welfare in the home and community.~~

~~5. The preadmission screening team must submit all preadmission screening information and a recommendation to DMAS for final determination of level of care and authorization for home and community based care services. DMAS or the designated preauthorization contractor authorization must be obtained prior to referral and Medicaid reimbursement for waiver services.~~

~~5. Home and community-based care services shall not be provided to any individual who resides in a nursing facility, an intermediate care facility for the mentally retarded, a hospital, an assisted living facility licensed or certified by DSS, or a group home licensed by the Department of Mental Health Mental Retardation Substance Abuse Services. Additionally, home and community-based care services shall not be provided to any individual who resides outside of the physical boundaries of the Commonwealth, with the exception of brief periods of time as approved by DMAS or the designated preauthorization contractor. Brief periods of time may include, but are not necessarily restricted to, vacation or illness.~~

~~6. The annual cost of care for home and community-based care services shall not exceed the average annual cost of inpatient hospital or nursing facility care. For purposes of this subdivision, the annual cost of care for home and community-based care services shall include all costs of all Medicaid covered services that would actually be received by recipients. The average annual cost of nursing facility care shall be determined by DMAS and shall be updated annually.~~

~~7. Individuals should not be screened multiple times within a short period of time for the same type of service. Preadmission screenings are valid for the following periods of time: (i) Month 0-6 – No updates needed; (ii)~~

Months 6-12 – Update needed (do not submit for reimbursement); and (iii) Over 12 Months Old – New screening must be completed (submit for reimbursement).

D. Appeals. Recipient appeals shall be considered pursuant to 12 VAC 30-110-10 through 12 VAC 30-110-380. Provider appeals shall be considered pursuant to 12 VAC 30-10-1000 and 12 VAC 30-20-500 through 12 VAC 30-20-560.

**12VAC30-120-160.-General conditions and requirements for all participating providers for home and community-based care services participating providers. for individuals with AIDS/ARC.**

A. All providers must meet the general requirements and conditions for provider participation. In addition, there are specific requirements for each of the service providers (case management, personal care, respite care, ~~and, skilled-private duty nursing, nutritional supplements~~ enteral nutrition, consumer-directed personal assistance services, and consumer-directed respite care services) which are set forth in ~~12VAC30-120-170-12VAC30-120-160~~155 through 12VAC30-120-200.

AB. General requirements. All ~~providers~~ Providers approved for participation shall, at a minimum, perform the following activities:

1. Immediately notify DMAS, in writing, of any change in the information which the provider previously submitted to DMAS to include the provider's physical and mailing addresses, executive staff and officers, and contact person's name, telephone number, and fax number.
2. Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the ~~service(s)~~service or services required and participating in the Medicaid Program at the time the service ~~or services~~ was were performed.
3. Assure the ~~recipient~~ recipient's ~~has~~ freedom to reject medical care and treatment.
4. Accept referrals for services only when staff is available to initiate services.
- ~~5. Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, religion, or national origin and of §504 of the Rehabilitation Act of 1973 which prohibits discrimination on the basis of a handicap.~~
5. Provide services and supplies to recipients in full compliance with (i) Title VI of the Civil Rights Act of 1964 (42 USC § 2000 et seq.) which prohibits discrimination on the grounds of race, color, religion, or national origin; (ii) § 504 of the Rehabilitation Act of 1973 (29 USC § 70 et seq.) which prohibits discrimination on the basis of disability; and (iii) Title II of the Americans with Disabilities Act of 1990 (42 USC § 126 et seq.) which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications.
6. Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.
7. Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.
8. Accept Medicaid payment from the first day of eligibility.

9. Accept as payment in full the amount established by ~~the~~ DMAS.
  10. Use program-designated billing forms for submission of charges.
  11. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope and details of the health care provided.
    - a. Such records shall be retained for at least five years from the last date of service or as provided by applicable federal or state laws, whichever period is longer. If an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years.
    - b. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of storage, location, and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth of Virginia.
  12. Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities. ~~authorized state and federal personnel, in the form and manner requested, access to records and facilities.~~
  13. Disclose, as requested by DMAS, ~~as requested by DMAS,~~ all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid.
  14. Hold confidential and use only for authorized DMAS purposes ~~only~~ all medical and identifying assistance information regarding recipients served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.
  15. ~~Change of ownership.~~ When ownership of the provider agency changes, notify DMAS ~~shall be notified~~ within 15 calendar days prior to the date of the change.
- ~~BC.~~ Requests for participation ~~Requests~~ will be screened by DMAS or the designated contractor to determine whether the provider applicant meets the basic requirements for participation.
- ~~CD.~~ ~~Provider participation standards.~~ For DMAS to approve contracts with home and community-based care providers, providers must meet staffing, financial solvency, disclosure of ownership and assurance of comparability of services requirements as specified in DMAS' AIDS Waiver Services Manual. ~~the following standards as defined in the provider manuals shall be met:~~
1. ~~Staffing requirements;~~
  2. ~~Financial solvency;~~
  3. ~~Disclosure of ownership; and~~
  4. ~~Assurance of comparability of services.~~

~~DE.~~ Adherence to provider contract and special participation conditions. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS the Department of Medical Assistance Services shall adhere to the conditions of participation outlined in their individual provider ~~contracts~~ agreements and in the applicable DMAS provider service manual.

F. DMAS is responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies.

~~EG.~~ Recipient choice of provider agencies. If there is more than one approved provider agency offering services in the community, the individual will have the option of selecting the provider agency of his choice from among those agencies that can appropriately meet the individual's needs.

H. If a participating provider wishes to voluntarily terminate his participation in Medicaid, the provider must give DMAS written notification 30 days prior to the desired termination date.

~~FI.~~ Termination of provider participation. DMAS may administratively terminate a provider from participation upon ~~60~~ 30 days written notification. DMAS may also cancel a provider agreement ~~contract~~ immediately or may give notification in the event of a breach of the provider agreement ~~contract~~ by the provider as specified in the DMAS provider agreement. ~~contract.~~ Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice. Payment by DMAS is prohibited for services provided to recipients subsequent to the date specified in the termination notice.

~~GJ.~~ Reconsideration of adverse actions. Adverse actions may include, but ~~are~~ shall not be limited to: disallowed payment of claims for services rendered which are not in accordance with DMAS policies and procedures, caseload restrictions, and contract limitation or termination. The following procedures will be available to all providers when DMAS takes adverse action: ~~which includes termination or suspension of the provider agreement.~~

1. The reconsideration process shall consist of three phases:

a. A written response and reconsideration to the preliminary findings;

b. ~~An~~ The informal conference; ~~;~~ and

c. ~~A~~ The formal evidentiary hearing.

2. The provider shall have 30 days to submit information for written reconsideration, ~~15~~ 30 days from the date of the notice to request ~~an~~ the informal conference, and ~~15~~ 30 days ~~from the date of the initial agency decision to request a~~ the formal evidentiary hearing.

3. An appeal of adverse actions shall be heard in accordance with 12 VAC 30-10-1000 and Part XII (12 VAC 30-20-500 et seq.) of 12 VAC 30-20. ~~the Administrative Process Act (§9-6.14:1 2.2 4000 et seq. of the Code of Virginia) and the State Plan. Judicial review of the final agency determination shall be made in accordance with the Administrative Process Act.~~

K. Section 32.1-325 C of the Code of Virginia mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify the Virginia Medicaid Program of this conviction and relinquish its provider agreement. Reinstatement will be contingent upon provisions of laws of the Commonwealth. Additionally, termination of a provider contract will occur as may be required for federal financial participation.

HL. Participating provider agency's responsibility for the ~~Recipient-Patient~~ Patient Information Form (DMAS-122). It is the responsibility of the provider agency to notify DMAS, or the designated preauthorization contractor, and the DSS, in writing, when any of the following circumstances occur:

1. Home and community-based care services are implemented;~~;~~
2. A recipient dies; ~~or~~
3. A recipient is discharged or terminated from services. ~~or~~
4. ~~Any other circumstances (including hospitalization) which cause home and community based care services to cease or be interrupted for more than 30 days.~~

M. Participating provider agency's responsibility for the Patient Information Form (DMAS-122). It is the responsibility of the provider agency to notify DSS, in writing, when any circumstances (including hospitalization) cause home and community-based care services to cease or be interrupted for more than 30 days.

IN. ~~Changes or termination of care. Agencies providing direct service are responsible for revisions to their individual service plan but must have any change which increases the amount of service or any change not agreed to by the recipient authorized by the case manager (refer to 12VAC30-120-170 12VAC30-120-160).~~

1. Decreases in the amount of authorized care by the provider agency.
  - a. ~~The provider agency may decrease the amount of authorized care only if the recipient agrees with the provider that a decrease in care is needed and that the amount of care in the revised Plan of Care if the newly developed plan of care is appropriate, and based on the needs of the individual. If the recipient disagrees with the proposed decrease, the recipient has the right to appeal to DMAS.~~
  - b. The participating provider is responsible for ~~devising~~ developing the new Plan of Care-plan of care and calculating the new hours of service delivery.
  - c. The provider shall discuss the decrease in care with the recipient and/or family, document the conversation in the recipient's record, and shall notify the recipient or family and the recipient's case manager of the change by letter. The participating provider shall give the recipient and/or family 10 days written notification of the intent to decrease services. The letter shall provide the reasons for and effective date of the decrease. The effective date of the decrease in service shall be at least five days from the date of the decrease notification letter.
  - d. The individual responsible for supervising the recipient's care shall discuss the decrease in care with the recipient or family, document the conversation in the recipient's record, and shall notify the designated preauthorization contractor and the recipient or family of the change by letter. This letter shall give the right to appeal.
  - e. ~~If the recipient disagrees with the decrease proposed, the provider shall contact the case manager to review the recipient's service needs and authorize the needed level of service.~~

2. Increases in the amount of authorized personal care. If a change in the recipient's condition (~~physical, mental, or social~~) necessitates an increase in care, the participating provider shall develop a Plan of Care for services to meet the changed needs and contact the case manager assigned to the recipient who will, if appropriate, authorize

~~the increase in service. The provider may implement the increase in hours once approval from the case manager is obtained.~~ shall assess the need for increase and, if appropriate, develop a plan of care for services to meet the changed needs. The provider may implement the increase in hours without approval from DMAS or the designated preauthorization contractor, if the amount of service does not exceed the amount established by DMAS or the designated preauthorization contractor, as the maximum for the level of care designated for that recipient. Any increase to a recipient's plan of care that exceeds the number of hours allowed for that recipient's level of care or any change in the recipient's level of care must be preauthorized by DMAS or the designated preauthorization contractor.

3. Nonemergency termination of home and community-based care services by the participating provider. The participating provider shall give the recipient and/or family, or both, five days' written notification of the intent to terminate services. The letter shall provide the reasons for and the effective date of the termination. The effective date of services termination shall be at least five days from the date of the termination notification letter.

4. Emergency termination of home and community-based care services by the participating provider. In an emergency situation when the health and safety of the recipient or provider agency personnel is endangered ~~the DMAS, or the designated preauthorization contractor,~~ must be notified prior to termination. The five-day written notification period shall not be required. If appropriate, the local DSS Adult Protective Services supervisor must be notified immediately.

~~5. Termination of home and community-based care services for a recipient by the case manager. The effective date of termination shall be at least 10 days from the date of the termination notification letter. The case manager has the responsibility and the authority to terminate home and community-based care services to the recipient for any of these reasons:~~

5. Termination of home and community-based care services by DMAS, or the designated preauthorization contractor. The effective date of termination will be at least ten days from the date of the termination notification letter. DMAS, or the designated preauthorization contractor, has the responsibility and the authority to terminate the receipt of home and community-based care services by the recipient for any of these reasons:

a. ~~The Home~~ home and community-based care services are no longer the critical alternative to prevent or delay institutional placement.

b. The recipient no longer meets the level-of-care criteria.

c. The recipient's environment does not provide for his health, safety, and welfare.; or

d. An appropriate and cost-effective ~~Plan of Care~~ plan of care cannot be developed.

6. If the recipient disagrees with the service termination decision, DMAS Appeals Division shall conduct a review of the recipient's service need as part of the appeals process. The recipient, when requesting an appeal should submit documentation to indicate why the decision to deny was incorrect. As a result of this review, DMAS Appeals Division will either uphold or overturn the termination decision. If the termination decision is upheld, the recipient has the right to file a formal appeal to the local circuit court.

~~JO.~~ Suspected abuse or neglect. Pursuant to ~~§63.1-55.3~~ 63.2-1606 of the Code of Virginia, if a participating provider agency knows or suspects that a home and community-based care recipient is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, ~~neglect,~~ or exploitation shall report this immediately to the local DSS Adult Protective Services and to DMAS.

~~KP. DMAS is responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies, and annually recertify each provider for contract renewal with DMAS to provide home and community based services. A provider's noncompliance with DMAS regulations, policies, and procedures, as required in the provider's contract, agreement with DMAS may result in a written request from DMAS for a corrective action plan which details the steps the provider will take and the length of time required to achieve full compliance with deficiencies which have been cited in a denial of Medicaid payment or termination of the provider agreement.~~

Q. Waiver desk reviews. DMAS will request, on an annual basis, information on every recipient, which is used to assess the recipient's ongoing need for Medicaid-funded long-term care. With this request, the provider will receive a list that specifies the information that is being requested. If a recipient is identified as not meeting criteria for the waiver, the recipient will be given ten days' notice of termination from services and be terminated from the waiver and will also be given appeal rights.

**12VAC30-120-165. Consumer-directed services: personal assistance and respite care services.**

A. Service definition.

1. Consumer-directed personal assistance services is care of either a supportive or health-related nature and may include, but is not limited to, assistance with activities of daily living, access to the community, monitoring of self-administration of medication or other medical needs, monitoring health status and physical condition, and work-related personal assistance. When specified on the plan of care, such supportive services may include assistance with instrumental activities of daily living (IADLs). Personal assistance does not include either practical or professional nursing services or those practices regulated in Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Subtitle III of Title 54.1 of the Code of Virginia, as appropriate.

2. Consumer-directed respite care services are specifically designed to provide temporary, periodic, or routine relief to the unpaid primary caregiver of an individual. Respite services include, but are not limited to, assistance with personal hygiene, nutritional support, and environmental support. This service may be provided in the individual's home or other community settings.

3. DMAS shall either provide for fiscal agent services or contract for the services of a fiscal agent for consumer-directed personal assistance services and consumer-directed respite care services. The fiscal agent will be reimbursed by DMAS to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle responsibilities for the individual for employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

4. Individuals choosing consumer-directed services must receive support from a CD services facilitator. This is not a separate waiver service, but is required in conjunction with consumer-directed personal assistance services, or consumer directed respite care services. The CD Service Facilitator is responsible for assessing the individual's particular needs for a requested CD service, assisting in the development of the plan of care, providing training to the individual and family/caregiver on his responsibilities as an employer, and providing ongoing support of the consumer-directed services. The CD service facilitator cannot be the individual, the individual's case manager, direct service provider, spouse, or parent of the individual who is a minor child, or a family/caregiver who is responsible for employing the assistant.

B. Criteria.

1. In order to qualify for consumer-directed personal assistance services, the individual must demonstrate a need for personal assistance in activities of daily living, community access, self-administration of medication, or other medical needs, or monitoring health status or physical condition.

2. Consumer-directed respite care services may only be offered to individuals who have an unpaid caregiver living in the home who requires temporary relief to avoid institutionalization of the individual. Respite services are designed to focus on the need of the unpaid caregiver for temporary relief and to help prevent the breakdown of the unpaid caregiver due to the physical burden and emotional stress of providing continuous support and care to the individual.

3. Individuals who are eligible for consumer-directed services must have the capability to hire and train their own personal assistants and supervise the assistant's performance. If an individual is unable to direct his own care or is under 18 years of age, a family/caregiver may serve as the employer on behalf of the individual.

4. The individual, or if the individual is unable, then a family/caregiver, shall be the employer of consumer directed services, and therefore shall be responsible for hiring, training, supervising, and firing assistants. Specific employer duties include checking of references of personal assistants, determining that personal assistants meet basic qualifications, training assistants, supervising the assistant's performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual or family/caregiver must have a back-up plan for the provision of services in case the assistant does not show up for work as expected or terminates employment without prior notice.

C. Service units and service limitations.

1. The unit of service for consumer-directed respite services is one hour. Consumer-directed respite services are limited to a maximum of 720 hours per calendar year. Individuals who receive consumer-directed respite care and agency-directed respite care services may not receive more than 720 hours combined in a calendar year.

2. No more than two unrelated individuals who live in the same home are permitted to share the authorized work hours of the assistant.

3. The unit of service for consumer-directed personal assistance services is one hour.

D. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12 VAC 30-120-145 and 12 VAC 30-120-150, the CD services facilitator must meet the following qualifications:

1. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the CD services facilitator shall have sufficient resources to perform the required activities. In addition, the CD services facilitator must have the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

2. It is preferred that the CD services facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth of Virginia. The CD services facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the provider's application form, found in supporting documentation, or be observed during the job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:

- (1) Types of functional limitations and health problems that may occur in persons with HIV/AIDS, as well as strategies to reduce limitations and health problems;
- (2) Physical assistance that may be required by persons with HIV/AIDS, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;
- (3) Equipment and environmental modifications that may be required by persons with HIV/AIDS that reduces the need for human help and improve safety;
- (4) Various long term care program requirements, including nursing facility and assisted living facility placement criteria, Medicaid waiver services, and other federal, state and local resources that provide personal assistance and respite care services;
- (5) DMAS HIV/AIDS waiver requirements, as well as the administrative duties for which the recipient will be responsible;
- (6) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning;
- (7) Interviewing techniques;
- (8) The recipient's right to make decisions about, direct the provisions of, and control his CD personal assistance and respite services, including hiring, training, managing, approving time sheets, and firing an assistant;
- (9) The principles of human behavior and interpersonal relationships; and
- (10) General principles of record documentation;

b. Skills in:

- (1) Negotiating with recipients and service providers;
- (2) Assessing, supporting, observing, recording, and reporting behaviors;
- (3) Identifying, developing, or providing services to recipients with HIV/AIDS, and
- (4) Identifying services within the established services system to meet the recipient's needs.

c. Abilities to:

- (1) Report findings of the assessment or onsite visit, either in writing or an alternative format for recipients who have visual impairments;
- (2) Demonstrate a positive regard for recipients and their families;

(3) Be persistent and remain objective;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, verbally and in writing; and

(6) Develop a rapport and communicate with different types of recipients from diverse cultural backgrounds.

3. If the CD services facilitator is not a registered nurse, the service facilitator must inform the primary health care provider that services are being provided and to request consultation as needed.

E. Service facilitation provider responsibilities.

1. The CD service facilitator shall maintain a personal assistant registry. The registry shall contain names of persons who have experience with providing personal assistance services or who are interested in providing personal assistance services. The registry shall be maintained as a supportive source for the recipient who may use the registry to obtain the names of potential personal assistants. The CD service facilitation provider shall note on the plan of care what constitutes the recipient's back-up plan in case the personal assistant does not report for work as expected or terminates employment without prior notice.

2. Upon the recipient's request, the CD service facilitation provider shall provide the recipient with a list of persons on the personal assistant registry who can provide temporary assistance until the assistant returns or the recipient is able to select and hire a new personal assistant. If a recipient is consistently unable to hire and retain the employment of an assistant to provide personal assistance services, the CD service facilitation provider must make arrangements with the case manager to have the services transferred to an agency-directed services provider or to discuss with the recipient and/or family/caregiver other service options.

3. For consumer-directed services, the CD services facilitator must make an initial comprehensive home visit to collaborate with the individual and family/caregiver to identify the needs, assist in the development of the plan of care with the individual or family/caregiver, and provide employee management training. Recipients or family/caregivers who cannot receive management training at the time of the initial visit must receive management training within seven days of the initial visit. The initial comprehensive home visit is done only once upon the individual's entry into the service. If a waiver individual changes CD services facilitators, the new CD services facilitator must complete a reassessment visit in lieu of a comprehensive visit.

4. After the initial visit, two routine onsite visits must occur in the recipient's home within 60 days of the initiation of care or the initial visit to monitor the plan of care. The first onsite visit shall occur within 30 days and the second onsite visit shall occur no later than 30 days after the first onsite visit. The CD service facilitator will continue to monitor the plan of care on an as needed basis, not to exceed a maximum of one routine onsite visit every 30 days but no less than the minimum of one routine onsite visit every 90 days per recipient. If additional onsite visits are required, the provider must have documentation to show the necessity for these extra visits. After the first two routine onsite visits, the CD services facilitator and recipient can decide on the frequency of the routine onsite visits.

5. After the initial visit, the CD services facilitator will continue to monitor the assistant's plan of care quarterly and on an as-needed basis. The CD services facilitator will review the utilization of consumer-directed respite services, either every six months or upon the use of 300 respite services hours, whichever comes first.

6. A face-to-face meeting with the individual must be conducted at least every 90 days to ensure appropriateness of any CD services received by the individual.

7. During visits with the individual, the CD services facilitator must observe, evaluate, and consult with the individual or family/caregiver, and document the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning and cognitive status, medical, and social needs. The CD services facilitator's written summary of the visit must include, but is not necessarily limited to:

a. Discussion with the individual or family/caregiver whether the service is adequate to meet the individual's needs;

b. Any suspected abuse, neglect, or exploitation and who it was reported to;

c. Any special tasks performed by the assistant and the assistant's qualifications to perform these tasks;

d. Individual's or family/caregiver's satisfaction with the service;

e. Any hospitalization or change in medical condition, functioning, or cognitive status;

f. The presence or absence of the assistant in the home during the CD services facilitator's visit; and

g. Other services received and the amount.

8. The CD services facilitator must be available to the individual by telephone.

9. Prior to a personal assistant providing services, the CD services facilitator must submit a criminal record check pertaining to the assistant on behalf of the individual and report findings of the criminal record check to the individual or the family/caregiver and the program's fiscal agent. If the individual is a minor, the assistant must also be screened through the DSS Child Protective Services Central Registry. Personal assistants will not be reimbursed for services provided to the individual on or after the date that the criminal record check confirms an assistant has been found to have been convicted of a crime as described in § 32.1-162.9:1 of the Code of Virginia or if the personal assistant has a confirmed record on the DSS Child Protective Services Registry. DMAS will reimburse for up to six criminal record checks per recipient within a six-month period.

10. The CD services facilitator, during routine visits, shall verify bi-weekly timesheets signed by the recipient or the family/caregiver and the personal assistant to ensure that the number of plan of care approved hours are not exceeded. If discrepancies are identified, the CD services facilitator must contact the recipient to resolve the discrepancies and must notify the fiscal agent. If a recipient is consistently being identified as having discrepancies in his timesheets, the CD services facilitator must contact the case manager to resolve the situation. The CD services facilitator cannot verify timesheets for personal assistants whose criminal record checks have confirmed that they have been convicted of a crime described in § 32.1-162.9:1 of the Code of Virginia or in the case of a minor recipient have a confirmed case with the DSS Child Protective Services Registry and must notify the fiscal agent.

11. The CD services facilitator must maintain records of each individual. At a minimum these records must contain:

a. All copies of the completed Uniform Assessment Instrument (UAI), all documentation of previous inpatient hospital admissions, the Long-Term Care Preadmission Screening Authorization (DMAS-96), the Screening

Team Service Plan (DMAS-97), the Consent to Exchange Information (DMAS-20), all Consumer Directed Personal Assistance Plans of Care (DMAS-97B), all Patient Information Forms (DMAS-122), the Outline and Checklist for Consumer Directed Recipient Comprehensive Training, and the Service Agreement Between the Consumer and the Service Facilitator;

b. Reassessments made during the provision of services;

c. All recipient progress reports;

d. Results of the initial comprehensive home visit completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation;

e. The plan of care goals and activities must be reviewed at least annually by the CD services facilitator, the recipient and family/caregiver receiving the services, and the case manager. In addition, the plan of care must be reviewed by the CD services facilitator quarterly, modified as appropriate, and submitted to the case manager;

f. CD service facilitator's dated notes documenting any contacts with the recipient, family/caregiver, and visits to the recipient's home;

g. All correspondence to the recipient, case manager, the designated preauthorization contractor, and DMAS;

h. Records of contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the recipient;

i. All training provided to the assistants on behalf of the recipient or family/caregiver;

j. All employee management training provided to the recipient or family/caregiver, including the recipient's or family/caregiver's receipt of training on their responsibility for the accuracy of the assistant's timesheets;

k. All documents signed by the recipient or the recipient's family/caregiver that acknowledge the responsibilities as the employer; and

l. Documentation that indicates the efforts taken by the service facilitator to obtain the most recently completed DMAS-122 from the case manager.

12. The CD service facilitation provider is required to submit to DMAS biannually, for every recipient, a recipient progress report, an updated UAI, documentation of any inpatient hospital admissions, and any monthly visit/progress reports. This information is used to assess the recipient's ongoing need for Medicaid-funded long-term care and appropriateness and adequacy of services rendered.

13. For consumer-directed personal assistance and consumer-directed respite services, individuals or family/caregivers will hire their own personal assistants and manage and supervise their performance. Assistant qualifications include, but shall not necessarily be limited to the following requirements. The assistant must:

a. Be 18 years of age or older;

b. Have the required skills to perform consumer-directed services as specified in the individual's plan of care;

c. Possess basic math, reading, and writing skills;

d. Possess a valid Social Security number;

e. Submit to a criminal records check and, if the individual is a minor, consent to a search of the DSS Child Protective Services Central Registry. The assistant will not be compensated for services provided to the individual if either of these records checks verifies the assistant has been convicted of crimes described in § 32.1-162.9:1 of the Code of Virginia or if the assistant has a founded complaint confirmed by the DSS Child Protective Services Central Registry;

f. Be willing to attend training at the individual's or family/ caregiver's request;

g. Understand and agree to comply with the DMAS AIDS waiver requirements;

h. Be willing to register in a personal assistant registry, which will be maintained by the provider agency chosen by the recipient; and

i. Receive yearly tuberculosis (TB) screening, cardiopulmonary resuscitation (CPR) training and an annual flu shot (unless these procedures are medically contraindicated).

13. Assistants may not be the parents of individuals who are minors or the individuals' spouses. Payment may not be made for services furnished by other family/caregivers living under the same roof as the individual being served unless there is objective written documentation as to why there are no other providers available to provide the care.

14. Family members who are reimbursed to provide consumer-directed services must meet the assistant qualifications.

F. Recipient responsibilities.

1. The recipient must be authorized for consumer-directed services and successfully complete management training performed by the service facilitator before the recipient can hire a personal assistant for Medicaid reimbursement. Recipients who are eligible for consumer-directed services must have the capability to hire and train their own personal assistants and supervise assistants' performance. Recipients with cognitive impairments will not be able to manage their own care. If a recipient is unable to direct his own care, a family caregiver may serve as the employer on behalf of the recipient. Recipients are permitted to share hours for no more than two individuals living in the same home.

2. The recipient or family/caregiver is the employer and is responsible for hiring, training, supervising, and firing personal assistants. Specific duties include checking references of personal assistants, determining that personal assistants meet basic qualifications, training personal assistants, supervising the personal assistants' performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The recipient must have an emergency back-up plan in case the personal assistant does not show up for work as expected or terminates employment without prior notice.

3. The recipient shall cooperate with the development of the plan of care with the service facilitation provider, who monitors the plan of care and provides supportive services to the recipient. The recipient shall also cooperate with the fiscal agent that handles fiscal responsibilities on behalf of the recipient. Recipients who do not cooperate with the service facilitation provider and fiscal agent will be disenrolled from consumer-directed services and will be considered for enrollment in agency-directed services.

4. Recipients will acknowledge that they will not knowingly continue to accept consumer-directed personal assistance services when the services are no longer appropriate or necessary for their care needs and will inform the service facilitation provider. If consumer-directed services continue after services have been terminated by DMAS or the designated preauthorization contractor, the recipient will be held liable for employee compensation.

5. The recipient's right to make decisions about, direct the provisions of, and control his consumer-directed personal assistance care and consumer-directed respite care services, including hiring, training, managing, approving time sheets, and firing an assistant shall be preserved.

G. Fiscal agent responsibilities.

1. DMAS shall be permitted to contract for the services of a fiscal agent for consumer-directed services. The fiscal agent will be reimbursed by DMAS to perform certain tasks as an agent for the recipient/employer who is receiving consumer-directed services. The fiscal agent will handle responsibilities for the recipient for employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

2. A fiscal agent may be a state agency or other organization, and will sign a contract with DMAS that clearly defines the roles and tasks expected of the fiscal agent and DMAS and enroll as a provider of consumer-directed services. Roles and tasks which will be deemed for the fiscal agent in the contract will consist of but not necessarily be limited to the following:

a. The fiscal agent will file for and obtain employer agent status with the federal and state tax authorities;

b. Once the recipient has been authorized to receive consumer-directed services, the fiscal agent will register the recipient as an employer, including providing assistance to the recipient in completing forms required to obtain employer identification numbers from federal agencies, state agencies, and unemployment insurance agencies;

c. The fiscal agent will prepare and maintain original and file copies of all forms needed to comply with federal, state, and local tax payment of unemployment compensation insurance premiums, and all other reporting requirements of employers;

d. Upon receipt of the required completed forms from the recipient, the fiscal agent will remit the required forms to the appropriate agency and maintain copies of the forms in the recipient's file. The fiscal agent will return copies of all forms to the recipient for the recipient's permanent personnel records;

e. The fiscal agent will prepare all unemployment tax filings on behalf of the recipient as employer, and make all deposits of unemployment taxes withheld according to the appropriate schedule;

f. The fiscal agent will receive and verify that the assistant's biweekly timesheets do not exceed the maximum hours approved for the recipient and will process the timesheets;

g. The fiscal agent will prepare and process the payroll for the recipient's assistants, performing appropriate income tax, FICA, and other withholdings according to federal and state regulations. Withholdings include, but are not limited to, all judgments, garnishments, tax levies, or any related holds on the funds of the assistants as may be required by local, state, or federal law;

h. The fiscal agent will prepare payrolls for the recipient's personal assistant according to approved time sheets and after making appropriate deductions;

i. The fiscal agent will make payments on behalf of the recipient for FICA (employer and employee shares), unemployment compensation taxes, and other payments required and as appropriate;

j. The fiscal agent will distribute biweekly payroll checks to the recipient's assistants on behalf of the recipients;

k. The fiscal agent will maintain accurate payroll records by preparing and submitting to DMAS, at the time the fiscal agent bills DMAS for personal assistance services, an accurate accounting of all payments on personal assistants to whom payments for services were made, including a report of FICA payments for each covered assistant;

l. The fiscal agent will maintain such other records and information as DMAS may require, in the form and manner prescribed by DMAS;

m. The fiscal agent will generate W-2 forms for all personal assistants who meet statutory threshold amounts during the tax year;

n. The fiscal agent will establish a customer service mechanism in order to respond to calls from recipients and personal assistants regarding lost or late checks, or other questions regarding payments that are not related to the authorization amounts generated from DMAS;

o. The fiscal agent will keep abreast of all applicable state and federal laws and regulations relevant to the responsibilities it has undertaken with regard to these filings;

p. The fiscal agent will use program-designated billing forms or electronic billing to bill DMAS, if this service is contracted; and

q. The fiscal agent will be capable of requesting electronic transfer of funds from DMAS.

3. The fiscal agent and all subcontracting bookkeeping firms, as appropriate, will maintain the confidentiality of Medicaid information in accordance with the following:

a. The fiscal agent agrees to ensure that access to Medicaid information will be limited to the fiscal agent. The fiscal agent shall take measures to prudently safeguard and protect unauthorized disclosure of the Medicaid information in its possession. The fiscal agent shall establish internal policies to ensure compliance with federal and state laws and regulations regarding confidentiality including, but not limited to, 42 CFR Part 431, Subpart F and Chapter 26 (§ 2.1-377 et seq.) of Title 2.1 of the Code of Virginia. In no event shall the fiscal agent provide, grant, allow, or otherwise give, access to Medicaid information to anyone without the express written permission of the DMAS Director. The fiscal agent shall assume all liabilities under both state and federal law in the event that the information is disclosed in any manner.

b. Upon the fiscal agent receiving any requests for Medicaid information from any individual, entity, corporation, partnership, or otherwise, the fiscal agent must notify DMAS of such requests within 24 hours of receipt of such requests. The fiscal agent shall ensure that there will be no disclosure of the data except through DMAS. DMAS will treat such requests in accordance with DMAS policies.

DEPT. OF MEDICAL ASSISTANCE SERVICES

HIV/AIDS Waiver Services

12 VAC 30-120-140 et. seq.

Page 23 of 42

c. In cases where the information requested by outside sources can be released under the Freedom of Information Act (FOIA), as determined by DMAS, the fiscal agent shall provide support for copying and invoicing such documents.

4. A contract between the fiscal agent and the recipient will be used to clearly express those aspects of the employment relationship that are to be handled by the fiscal agent, and which are to be handled by the recipient. The contract will reflect that the fiscal agent is performing these tasks on behalf of the recipient who is the actual employer of the assistant. Before the recipient begins receiving services, the fiscal agent must have a signed contract with the recipient prior to the reimbursement of personal assistance services.

**12VAC30-120-170. Case management services.**

The following are specific requirements governing the provision of case management services. ~~Case management is one of five seven services covered under the home and community based care program for individuals with AIDS/ARC.~~

A. General. Case management services are offered to enable continuous assessment, coordination and monitoring of the needs of AIDS Waiver recipients. ~~the persons diagnosed with AIDS or ARC throughout the term of the individual's receipt of waiver services.~~ Every AIDS /ARC individual recipient authorized for home and community-based services shall be offered case management services as an adjunct to other offered services. A Medicaid-eligible recipient individual may not be authorized for home and community-based services unless that recipient individual is both diagnosed with AIDS ~~or ARC~~ and is experiencing symptoms that which require delivery of a home and community-based service other than case management. ~~An individual~~ A recipient authorized for home and community-based services for conditions of AIDS ~~/ARC~~ may continue to receive case management services during periods when other home and community-based services are not being utilized as long as receipt of case management services can be shown to continue to prevent the individual's recipient's institutionalization. In instances where a case management provider cannot be located, one of the other providers (personal/respite care provider, private duty nursing provider, or consumer directed service facilitation provider) may act as the case management provider as long as they meet the case management provider qualifications and are enrolled with DMAS to provide case management services. If an AIDS Waiver recipient requires case management services, this service should be provided as a part of the AIDS Waiver. There shall be no duplication of AIDS Waiver case management services with other Medicaid State Plan case management services.

B. Special provider participation conditions. To be a participating case management provider the following conditions shall be met:

1. The provider shall employ case management staff responsible for the reevaluation of need, monitoring of service delivery, revisions to the Plan of Care plan of care and coordination of services. ~~This staff shall possess, at a minimum:~~ Each case manager shall possess, at a minimum:

a. A baccalaureate degree in human services (i.e., social work, psychology, sociology, counseling, or a related field) or nursing;

b. Knowledge of the infectious disease process (specifically HIV) and the needs of the terminally-ill population, knowledge of the community service network and eligibility requirements, and the application procedures for applicable assistance programs;

DEPT. OF MEDICAL ASSISTANCE SERVICES

HIV/AIDS Waiver Services

12 VAC 30-120-140 et. seq.

Page 24 of 42

c. Ability to access other health and social work professionals in the community to serve as members of a multidisciplinary team for reevaluation and coordination of services activities, ability to organize and monitor an integrated service plan for ~~individuals~~ recipients with multiple problems and limited resources, ability to access (or have expertise in) medical and clinical expertise related to HIV infection and ability to demonstrate liaisons with clinical facilities providing diagnostic evaluation and/or treatment for persons with HIV; and

d. Skills in communication, service plan development, client advocacy, and monitoring of a continuum of managed care.

Documentation of all staffs' credentials shall be maintained in the provider agency's personnel file for review by DMAS staff. Providers of case management may utilize the services of volunteers or employees who do not meet ~~this~~ these criteria to perform the day-to-day interactions with recipients commonly included in the case management process. There shall be, however, a case manager responsible for supervision of these volunteers or employees to include at a minimum weekly case consultations, decision-making related to the ~~individual's Plan of Care~~ recipient's plan of care and appropriateness for waiver services and training of the volunteers or employees interacting with the waiver recipient. The use of volunteers or other employees to perform the day-to-day interactions does not relieve the case manager from responsibility for direct contact (as defined below) with the recipient and overall responsibility for care management.

2. Designate a qualified staff person as case manager who shall:

a. Complete a comprehensive initial assessment.

~~ab.~~ Contact the waiver recipient, at a minimum, once every 30 days. If the waiver recipient has a volunteer(s) or other staff assigned for regular face-to face contact, this contact by the case manager may be a telephone contact. Otherwise, the contact by the case manager shall be a face-to-face interaction. At a minimum, the case manager must have face-to-face contact with the recipient quarterly.

~~bc.~~ Contact the providers of direct waiver service(s), at a minimum, once every 30 days. Collateral contacts with other supports shall be made periodically, as determined by the needs of the recipient and extent of the support system. Contacts must be documented in the recipient's record.

~~ed.~~ Maintain a file for each recipient ~~which~~ that includes:

(1) An ongoing progress report ~~which~~ that documents all communications between the case manager and recipient, providers, and other contacts. This must include the amount of time the case manager interacted with the recipient on the telephone or face-to-face. If the case manager is supervising a volunteer or employee who is assigned to provide day-to-day case management interactions with the recipient, the volunteer or employee must submit to the case manager a monthly summary of all interactions between the volunteer or employee and the recipient,

(2) The recipient's assessment documentation and documentation of reassessments of level of care and need for services conducted quarterly by the case manager and the ~~individual's~~ recipient's case management team,

(3) The initial ~~Plan of Care~~ plan of care and all subsequent revisions, and

(4) Communication from DMAS, physician, service providers, and any other parties related to the recipient's Medicaid services or medical care.

~~de. Review~~ Reviews of the ~~Plan of Care~~ plan of care every three months, or more frequently if necessary, and continue any revisions indicated by the changed needs or support of the recipient. These reviews shall be documented in the recipient's file. The documentation shall note all members of the case management team who provided input to the ~~Plan of Care~~ plan of care.

3. Maintain a ratio of case manager staff to recipient caseload ~~which~~ that allows optimum monitoring and reevaluation ability. The caseload ability of the case manager may vary according to other duties, availability of resources, stage of recipients in caseload, and utilization of volunteers. ~~A ratio of one case manager to a caseload size of 25 waiver recipients is deemed desirable, but can be exceeded as long as the quality of case management services are not affected.~~

~~C. Nutritional supplement authorization. Nutritional supplements which do not contain a legend drug may be purchased for the recipient of waiver services for conditions of AIDS/ARC when the nutritional supplements are certified by the physician as the primary source of nutrition and necessary for the successful implementation of the individual's health care plan and the individual is not able to purchase these food supplements through other available means. The amount of nutritional supplements shall be limited by medical necessity and cost effectiveness. Case management providers shall authorize the purchase of physician ordered nutritional supplements through the Plan of Care approved by DMAS or the designated preauthorization contractor. The case management provider shall complete an invoice authorizing the purchase which the recipient can use to purchase the nonlegend drug nutritional supplements from an approved Medicaid provider.~~

**12VAC30-120-180. Agency directed personal ~~Personal~~ care services.**

The following requirements govern the provision of personal care services:

A. General. Personal care services ~~are~~ may be offered to ~~individuals in their homes~~ an individual recipients as an alternative to institutional care. Personal care may be offered either as the sole home and community-based care service that avoids institutionalization or in conjunction with the other AIDS Waiver services. ~~as long term maintenance or support services which are necessary in order to enable the individual to remain at or return home rather than enter a hospital or nursing facility.~~ Personal care services provide eligible individuals with personal care aides who perform basic health related services, such as helping with activities of daily living, assisting with ambulation, exercises, assisting with normally self-administered medications, reporting changes in recipient's conditions and needs, and/or providing household services essential to health in the home. Generally, personal care ~~services include assistance with personal hygiene, nutritional support, and the environmental maintenance necessary for recipients to remain in their homes.~~ Recipients may continue to work or attend post-secondary school, or both, while they receive services under this waiver. The personal care assistant who assists the recipient may accompany ~~that person~~ the recipient to work or school or both and may assist the ~~person~~ recipient with personal needs while the ~~individual~~ recipient is at work or school or both. DMAS will also pay for any personal care services that the assistant gives to the enrolled recipient to assist him in getting ready for work or school or both or when he returns home.

DMAS or the designated preauthorization contractor will review the recipient's needs and the complexity of the disability when determining the services that will be provided to the recipient in the workplace or school or both.

B. DMAS will not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (ADA) (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973. For example, if the recipient's only need is for assistance during lunch, DMAS would not pay for the assistant to be with the recipient for any hours extending beyond lunch. For a recipient whose speech is such that he cannot be understood

without an interpreter (not translation of a foreign language), or the recipient is physically unable to speak or make himself understood even with a communication device, the assistant's services may be necessary for the length of time the recipient is at work or school or both. DMAS will reimburse for the assistant's services unless the assistant is required to assist the recipient for the length of time the recipient is at work or school or both as a part of the ADA or Rehabilitation Act. ~~except for assistance services that are required to be provided by the employer or school under the ADA or the Rehabilitation Act but only to the extent such time and services are consistent with the recipient's plan of care.~~

C. The provider agency must develop an individualized plan of care that addresses the recipient's needs at home, ~~at~~ and work and in the community. DMAS will not pay for the assistant to assist the enrolled recipient with any functions related to the recipient completing his job or school functions or for supervision time during work, ~~or~~ school, or both.

D. Special provider participation conditions. The personal care provider shall:

~~1. Demonstrate a prior successful delivery of health care services.~~

21. Operate from a business office.

32. Employ (or subcontract with) and directly supervise ~~at least~~ a registered nurse (~~RN~~) who will provide ongoing supervision of all personal care aides.

a. The ~~Rn~~ registered nurse shall be currently licensed to practice in the Commonwealth of Virginia and have at least two years of related clinical nursing experience (which may include work in ~~a~~ an acute care hospital, public health clinic, home health agency, rehabilitation hospital, ~~or nursing home, facility,~~ or as a ~~Licensed Practical Nurse-licensed practical nurse (LPN)).~~

b. The registered nurse shall have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check documentation shall be available for review by DMAS staff who are authorized by the agency to review these files, as a part of the utilization review process.

~~bc.~~ The ~~Rn~~ registered nurse supervisor shall make an initial home assessment home-visit prior on or before to the start of care for all new recipients admitted to personal care, when a recipient is readmitted after being discharged from services, or is transferred from another personal care provider.

~~ed.~~ The RN shall make supervisory visits as often as needed to ensure both quality and appropriateness of services. A minimum frequency of these visits is every 30 days. The ~~Rn~~ registered nurse supervisor shall make supervisory visits as often as needed, but no fewer visits than provided as follows, to ensure both quality and appropriateness of services.

(1) A minimum frequency of these visits is every 30 days for recipients with a cognitive impairment, as defined herein, and every 90 days for recipients who do not have a cognitive impairment.

(2) The initial home assessment visit by the ~~Rn~~ registered nurse shall be conducted to create the plan of care and assess the recipients' needs. The ~~RN supervisor-registered nurse~~ shall return for a follow-up visit within 30 days after the initial visit to assess the recipient's needs and make a final determination that there is no cognitive impairment. This determination must be documented in the recipient's record by the ~~Rn~~ registered nurse.

~~supervisor.~~ Recipients who are determined to have a cognitive impairment will continue to have supervisory visits every 30 days.

(3) If there is no cognitive impairment, the ~~RN-supervisor~~ registered nurse may give the recipient or ~~family/caregiver~~ or both the option of having the supervisory visit every 90 days or any increment in between, not to exceed 90 days. The ~~RN-supervisor~~ registered nurse must document this conversation in the recipient's record ~~this conversation~~ and the option that was chosen.

(4) The provider ~~agency~~ has the responsibility of determining if 30-day ~~RN~~ registered nurse supervisory visits are appropriate for the recipient. The provider ~~agency~~ may offer the extended ~~RN-supervisor~~ registered nurse supervisor supervisory visits, or the agency may choose to continue the 30-day supervisory visits based on the needs of the individual. The decision must be documented in the recipient's record.

(5) If a recipient's personal care assistant is supervised by the provider's registered nurse less often than every 30 days and DMAS or the designated preauthorization contractor determines that the recipient's health, safety, or welfare is in jeopardy, DMAS or the designated preauthorization contractor, may require the provider's registered nurse to supervise the personal care aide every 30 days or more frequently than what has been determined by the registered nurse. This will be documented and entered in the recipient's record.

~~de.~~ During visits to the recipient's home, ~~the RN-~~ a registered nurse shall observe, evaluate, and document the adequacy and appropriateness of personal care services with regard to the recipient's current functioning status, medical, and social needs. The personal care aide's record shall be reviewed and the recipient's (or family's) satisfaction with the type and amount of service discussed. The ~~RN-~~ registered nurse summary shall note:

- (1) Whether personal care services continue to be appropriate.
- (2) Whether the plan is adequate to meet the ~~need or changes are indicated in the plan.~~ recipient's needs or if changes need to be made in the plan of care;
- (3) Any special tasks performed by the aide and the aide's qualifications to perform these tasks.
- (4) Recipient's satisfaction with the service.
- (5) Hospitalization or change in the medical condition or functioning status of the recipient.
- (6) Other services received ~~and their amount.~~ by the recipient and the amount; and
- (7) The presence or absence of the aide in the home during the ~~RN's-~~ registered nurse's visit.

~~ef.~~ ~~The~~ A registered nurse shall be available to the personal care aide for conference pertaining to ~~individuals~~ recipients being served by the aide and shall be available to ~~aide-~~ aides by telephone at all times that the aide is providing services to personal care recipients.

~~fg.~~ The ~~RN-~~ registered nurse supervisor shall evaluate the ~~aide's~~ aides' performance and the recipient's ~~individual~~ needs to identify any ~~gaps-~~ insufficiencies in the aide's abilities to function competently and shall provide training as indicated. This shall be documented in the recipient's record.

h. If there is a delay in the registered nurses' supervisory visits, because the recipient was unavailable, the reason for the delay must be documented in the recipient's record.

43. Employ and directly supervise personal care aides who ~~will~~ provide direct care to personal care recipients. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with ~~minimum~~ qualifications as required by DMAS. Each aide shall:

- a. ~~Shall be~~ Be able to read and write in English to the degree necessary to perform the expected tasks.
- b. ~~Shall complete~~ Complete a minimum of 40 hours of training consistent with DMAS standards. Prior to assigning an aide to a recipient, the provider agency shall ensure that the aide has satisfactorily completed a training program consistent with DMAS standards.
- c. ~~Shall be~~ Be physically able to do the work.
- d. ~~Shall have~~ Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of ~~possible~~ abuse, neglect or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files;
- e. ~~Shall not be a member of the recipient's family (e.g., family is defined as parents, spouses, children, siblings, grandparents, and grandchildren). parents of minor children or spouses. Not be (i) the parents of minor children who are receiving waiver services; (ii) spouses of individuals who are receiving waiver services; and~~
- f. Payment may be made for services furnished by other family members when there is objective written documentation as to why there are no other providers available to provide the care. These family members must meet the same requirements as aides who are not family members.

~~E. Provider inability to render services and substitution of aides.~~

~~1. When a personal care aide is absent and the agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to recipients. The agency may either obtain a substitute aide from another agency, if the lapse in coverage is to be less than two weeks in duration, or may transfer the recipient to another agency. If no other provider agency is available, the provider agency shall notify the recipient or family so they may contact the local health department to request a nursing home preadmission screening if nursing home placement is desired.~~

~~2. During temporary, short term lapses in coverage (not to exceed two weeks in duration), the following procedure shall apply:~~

- a. ~~The personal care agency having recipient responsibility shall provide the registered nurse supervision for the substitute aide.~~
- b. ~~The agency providing the substitute aide shall send to the personal care agency having recipient care responsibility a copy of the aide's signed daily records signed by the recipient.~~
- c. ~~The provider agency having recipient responsibility shall bill DMAS for services rendered by the substitute aide. The two agencies involved shall negotiate the financial arrangements of paying the substitute aide.~~

~~3. If a provider agency secures a substitute aide, the provider agency shall be responsible for ensuring that all DMAS requirements continue to be met, including documentation of services rendered by the substitute aide and documentation that the substitute aide's qualifications meet DMAS requirements.~~

FC. Required documentation in for recipients' records. The provider agency shall maintain all records of each personal care recipient. At a minimum these records shall contain: These records shall be separate from those of non-home and community-based care services, such as companion or home health services. These records shall be reviewed periodically by the DMAS staff who are authorized by the agency to review these files during utilization review. At a minimum the record shall contain:

1. The most recently updated Long- Term Care Uniform Assessment Instrument (UAI), documentation of any inpatient hospital admissions, the Prescreening Authorization, Medicaid-Funded Long-Term Care Service Authorization form (DMAS-96), the Screening Team Plan of Care, Service Plan for Medicaid-Funded Long-Term Care (DMAS-97), the Consent to Exchange Information (DMAS-20), all provider agency plans of care Provider Agency Plans of Care (DMAS-97A), and all Community-Based Care Recipient Assessment Reports (DMAS-99), all Patient Information Forms (DMAS-122s), and the Service Agreement Between the Consumer and the Service Facilitator.

~~2. All DMAS Utilization Review forms and plans of care.~~

~~32. The initial initial assessment by the RN a registered nurse supervisory nurse completed prior to or on the date that services are initiated.~~

~~43. Nurses' Registered nurses' notes recorded and dated during any significant contacts with the personal care aide and during supervisory visits to the recipient's home.~~

~~54. All correspondence to the recipient, and to DMAS, and the designated preauthorization contractor.~~

~~65. Reassessments made during the provision of services~~

76. Significant Contacts contacts made with family, physicians, DMAS, the designated preauthorization contractor, formal and informal service providers, and all professionals concerning the recipient, related to the recipient's Medicaid services or medical care;

~~87. All personal care aide records. The personal care aide record shall contain:~~All Provider Aide/LPN Records (DMAS-90). The Provider Aide/LPN Record shall contain:

a. The specific services delivered to the recipient by the aide and the recipient's ~~responses.~~response to this service;

b. The aide's daily arrival and departure times.

c. The aide's weekly comments or observations about the recipient, including ~~to include~~ observations of the recipient's physical and emotional condition, daily activities, and responses to services rendered.; and

d. The aide's and recipient's, or responsible caregiver's, weekly ~~signature~~signatures, including the date, to verify that personal care services ~~during that week have been rendered.~~have been rendered during that week as documented in the record. An employee of the provider cannot sign for the recipient unless he is a family member or legal guardian of the recipient;

~~e.~~ Signatures, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered.; and

8. All recipient progress reports.

**12VAC30-120-190. Agency directed respite ~~Respite care services.~~**

These requirements govern the provision of respite care services.

A. General. Respite care services may be offered to ~~individuals in their homes~~ recipients as an alternative to ~~more~~ ~~costly~~ institutional care. Respite care may be offered to recipients in their home or place of residence, in a Medicaid-certified nursing facility, or in a licensed respite care facility. Respite care is distinguished from other services in the continuum of long-term care because it is specifically designed to focus on the need of the unpaid primary caregiver for temporary relief. Respite care may only be offered to ~~individuals~~ recipients who have a an unpaid primary caregiver living in the home who requires temporary relief to avoid institutionalization of the recipient. ~~individual. The authorization of respite care is limited to 30 24 hour days over a 12 month period. Reimbursement shall be made on an hourly basis.~~ The authorization of respite care is limited to 720 hours per calendar year per recipient. A recipient who transfers to a different provider or is discharged and readmitted into the HIV/AIDS waiver program within the same calendar year will not receive an additional 720 hours of respite care. ~~DMAS cannot be billed for more than 720 respite care hours in a calendar year for a waiver recipient.~~ Reimbursement shall be made on an hourly basis not to exceed a total of 720 hours per calendar year. If a recipient is receiving both agency directed and consumer directed respite care, the total number of respite care hours cannot exceed a total of 720 hours combined per calendar year.

B. Special provider participation conditions. To be approved for respite care contracts with DMAS, the respite care provider shall:

~~1. Demonstrate prior successful health care delivery.~~

~~2~~1. Operate from a business office.

~~3~~2. Employ (or subcontract with) and directly supervise a registered nurse (~~RN~~) who will provide ongoing supervision of all respite care aides.

a. The ~~RN~~ registered nurse shall be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience (which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, ~~or nursing home facility~~, or as an LPN.

b. The registered nurse shall have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files.

~~b~~c. Based on continuing evaluations of the aides' performance and the recipients' individual needs, ~~the RN~~ a registered nurse supervisor shall identify any ~~gaps~~ insufficiencies in the aides' abilities to function competently and shall provide training as indicated.

~~ed.~~ ~~The RN-~~ A registered nurse supervisor shall make an initial home assessment visit on or before ~~prior to~~ the start of care for any recipient admitted to respite care.

~~de.~~ ~~The A registered nurse RN-~~ supervisor shall make supervisory visits as often as needed to ensure both quality and appropriateness of services.

(1) When respite care services are received on a routine basis, the minimum acceptable frequency of these visits shall be every 30 days.

~~(2) When respite care services are not received on a routine basis, but are episodic in nature, the RN supervisor shall not be required to conduct a supervisory visit every 30 days. Instead, the RN supervisor shall conduct the initial home visit with the respite care aide immediately preceding the start of care and make a second home visit within the respite care period. When respite care services are not received on a routine basis, but are episodic in nature, an Rna registered nurse shall not be required to conduct a supervisory visit every 30 days. Instead, an Rna registered nurse shall conduct the initial home assessment visit with the respite care aide on or before the start of care and make a second home visit during the second respite care visit.~~

~~(3) When respite care services are routine in nature and offered in conjunction with personal care, the 30-day supervisory visit conducted for personal care may serve as the RN visit for respite care. However, the RN supervisor shall document supervision of respite care separately. For this purpose, the same recipient record can be used with a separate section for respite care documentation. When respite care services are routine in nature and offered in conjunction with personal care, the supervisory visit conducted for personal care services may serve as the registered nurse supervisory visit for respite care. However, the registered nurse supervisor shall document supervision of respite care separately from the personal care documentation. For this purpose, the same recipient record can be used with a separate section for respite care documentation.~~

~~ef.~~ During visits to the recipient's home, the ~~Rn-~~ registered nurse shall observe, evaluate, and document the adequacy and appropriateness of respite care services with regard to the recipient's current functioning status, medical, and social needs. The respite care aide's record shall be reviewed along with ~~and~~ the recipient's or family's satisfaction with the type and amount of service discussed. The ~~RN-~~ registered nurse shall document in a summary note:

(1) Whether respite care services continue to be appropriate.

(2) Whether the ~~Plan of Care-~~ plan of care is adequate to meet the recipient's needs or if changes need to be made ~~in it. to the plan of care;~~

(3) The recipient's satisfaction with the service.

(4) Any hospitalization or change in the medical condition or functioning status; ~~of the recipient;~~

(5) Other services received ~~and their amount.~~ by the recipient and the amount of services received; ~~and~~

(6) The presence or absence of the aide in the home during the ~~visit-~~ registered nurse's visit.

~~fg.~~ ~~A Rn-~~ A registered nurse shall be available to the respite care aide ~~to discuss the recipients being served by the aide. for conference pertaining to recipients being served by the aide and shall be available to the aides by telephone at all times that aides are providing services to respite care recipients.~~

~~g. The RN providing supervision to respite care aides shall be available to them by telephone at all times that services are being provided to respite care recipients. Any lapse in RN coverage shall be reported immediately to DMAS.~~

h. If there is a delay in the registered nurse's supervisory visits, because the recipient is unavailable, the reason for the delay must be documented in the recipient's record.

43. Employ and directly supervise respite care aides who provide direct care to respite care recipients. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with ~~minimum~~ qualifications. ~~Each aide:~~ as required by DMAS. Each aide must:

a. ~~Shall be~~ Be able to read and write: in English to the degree necessary to perform the tasks expected;

b. ~~Shall have~~ Have completed a minimum of 40 hours of training consistent with DMAS standards. Prior to assigning an aide to a recipient, the provider agency shall ensure that the aide has satisfactorily completed a training program consistent with DMAS standards.

c. ~~Shall be~~ Be evaluated in his job performance by the RN-registered nurse supervisor.

d. ~~Shall have the physical ability to do the work.~~ Be physically able to do the work;

e. ~~Shall have~~ Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of possible abuse, or neglect, or exploitation of incompetent and/or incapacitated individuals, of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check documentation shall be available for review by DMAS staff who are authorized by the agency to review these files;

f. ~~Shall not be a member of a recipient's family (e.g., family is defined as parents, spouses, siblings, grandparents, and grandchildren).~~ parents of minor children or spouses.

f. Not be (i) the parents of minor children who are receiving waiver services, or (ii) the spouses of individuals who are receiving waiver services; and

g. Payment may be made for services furnished by other family members when there is objective written documentation as to why there are no other providers available to provide the care. These family members must meet the same requirements as aides who are not family members.

54. The respite care agency may employ a licensed practical nurse (LPN) to ~~deliver~~ perform skilled respite care services, which shall be reimbursed by DMAS under the following circumstances:

a. The LPN shall be currently licensed to practice in the Commonwealth. The LPN must have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers shall be responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check documentation shall be available for review by DMAS staff who are authorized by the agency to review these files.

~~ab. The individual receiving care recipient~~ has a need for routine skilled care which that cannot be provided by unlicensed personnel. These individuals This recipient would typically require a skilled level of care if in a

nursing ~~home facility~~ (i.e., recipients on a ventilator, recipients requiring nasogastric or gastrostomy feedings, etc.);

~~bc.~~ No other individual in the recipient's support system is able to supply the skilled component of the recipient's care during the caregiver's absence.

~~ed.~~ The recipient is unable to receive skilled nursing visits from any other source which could provide the skilled care usually given by the caregiver.

~~de.~~ The agency ~~can~~ must document in the recipient's record the circumstances which require the provision of services by an LPN;

f. A physician's order for the skilled respite service, on the Home Health Certification and Plan of Care (CMS-485), is obtained prior to the initiation of service and is updated every six months. This order must specifically identify the skilled tasks to be performed; and

g. The registered nurse shall review the medications and treatments rendered by the LPN every 60 days and verify the physician's orders.

~~C. Inability to provide services and substitution of aides. When a respite care aide is absent and the respite care provider agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to recipients.~~

~~1. If a provider agency cannot supply a respite care aide to render authorized services, the agency may either obtain a substitute aide from another agency, if the lapse in coverage is to be less than two weeks in duration, or may transfer the recipient's care to another agency.~~

~~2. If no other provider agency is available who can supply an aide, the provider agency shall notify the recipient or family and case manager.~~

~~3. If a substitute aide is secured from another respite care provider agency or other home care agency, the following procedures apply:~~

~~a. The respite care agency having recipient responsibility shall be responsible for providing the RN supervision for the substitute aide.~~

~~b. The agency providing the substitute aide shall send to the respite care agency having recipient care responsibility a copy of the aide's daily records signed by the recipient, and the substitute aide. All documentation of services rendered by the substitute aide shall be in the recipient's record. The documentation of the substitute aide's qualifications shall also be obtained and recorded in the personnel files of the agency having recipient care responsibility.~~

~~c. The provider agency having recipient responsibility shall bill DMAS for services rendered by the substitute aide. The two agencies involved shall negotiate the financial arrangements of paying the substitute aide.~~

~~4. Substitute aides obtained from other agencies may be used only in cases where no other arrangements can be made for recipient respite care services coverage and may be used only on a temporary basis. If a substitute aide is needed for more than two weeks, the case shall be transferred to another respite care provider agency that has the aide capability to serve recipients.~~

~~5. If a provider agency secures a substitute aide it is the responsibility of the provider agency having recipient care responsibility to ensure that all DMAS requirements continue to be met, including documentation of services rendered by the substitute aide and documentation that the substitute aide's qualifications meet DMAS requirements.~~

~~DC.~~ Required documentation for ~~recipients~~ recipients' records. The provider agency shall maintain all records of each respite care recipient. These records shall be ~~separated~~ separate from those of ~~other~~ non-home and community-based care services, such as companion ~~services~~ or home health services. These records shall be reviewed periodically by the DMAS staff who are authorized by the agency to review these files during utilization review. At a minimum these records shall contain:

1. The most recently updated Long Term Care Uniform Assessment Instrument (UAI), documentation of any inpatient hospital admissions, the Prescreening Authorization, all Respite Care Assessment and Plans of Care, and all DMAS-122s, Medicaid-Funded Long-Term Care Service Authorization form (DMAS-96), the Screening Team Service Plan for Medicaid-Funded Long-Term Care (DMAS-97), all Community-Based Care Assessment Reports (DMAS-99), all Provider Agency Plans of Care (DMAS-97A and CMS-485), and all Patient Information Forms (DMAS-122);

~~2. All DMAS Utilization Review Forms and Plans of Care.~~

~~3.~~ The initial initial assessment by ~~the RN~~ a registered nurse supervisor completed prior to or on the date services are initiated.

~~4.~~ Registered nurse's notes recorded and dated during significant contacts with the respite care aide or LPN and during supervisory visits to the recipient's home.

~~5.~~ All correspondence to the recipient, and to DMAS, and the designated preauthorization contractor.

6. Reassessments made during the provision of services.

7. Significant contacts made with family, physicians, DMAS, the designated preauthorization contractor, formal and informal service providers, and all professionals ~~concerning the recipient.~~ related to the recipient's Medicaid services or medical care; and

8. ~~All Respite Provider Aide/LPN Records (DMAS-90) -care aide record of services rendered and recipient's responses.~~ The Provider Aide/LPN Record ~~aide record~~ shall contain:

a. The specific services delivered to the recipient by the respite care aide, or LPN, and the recipient's response to this service.

b. The daily arrival and departure ~~time~~ times of the aide or LPN for respite care services ~~only.~~

c. Comments or observations recorded weekly about the recipient. Aide or LPN comments shall include but not be limited to observation of the recipient's physical and emotional condition, daily activities, and the recipient's response to services rendered; and

d. The ~~signature by~~ signatures of the aide, or LPN, and the recipient, once each week to verify that respite care services have been rendered.

~~e. Signature~~ Signatures, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered. If the recipient is unable to sign the aide record, it must be documented in the recipient's record how or who will sign in his place. An employee of the provider shall not sign for the recipient unless he is a family member or legal guardian of the recipient and has direct knowledge of the care received by the recipient.

9. All recipient progress reports.

~~9. Copies of all aide records shall be subject to review by state and federal Medicaid representatives.~~

~~10. If a respite care recipient is also receiving any other service (meals on wheels, companion, home health services, etc.), the respite care record shall indicate that these services are also being received by the recipient.~~

**12 VAC 30-120-195. Enteral nutrition.**

**A. General requirements and conditions.**

1. Enteral nutrition shall only be provided by enrolled durable medical equipment providers.

2. DME providers shall adhere to all applicable DMAS policies, laws, and regulations for enteral nutrition. DME providers shall also comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations shall result in denial of coverage for enteral nutrition that is regulated by such licensing agency or agencies.

**B. Service units and service limitations.**

1. DME and supplies must be furnished pursuant to the AIDS Waiver Enteral Nutrition Evaluation Form (DMAS-116).

2. A DMAS-116 shall be required for all AIDS Waiver recipients receiving enteral nutrition. Enteral nutrition that does not contain a legend drug may be obtained for the recipient of waiver services for conditions of AIDS when the enteral nutrition is certified by the physician as the primary source of nutrition, is administered orally or through a nasogastric or gastrostomy tube, and is necessary for the successful implementation of the individual's health care plan and the individual is not able to purchase enteral nutrition through other means. Coverage of enteral nutrition does not include the provision of routine infant formula. The amount of enteral nutrition shall be limited by medical necessity and cost-effectiveness.

3. "Primary source" means that enteral nutrition is medically indicated for the treatment of the recipient's condition if the recipient is unable to tolerate nutrients. The recipient may either be unable to take any oral nutrition or the oral intake that can be tolerated is inadequate to sustain life. The focus must be the maintenance of weight and strength commensurate with the recipient's medical condition.

4. The DMAS-116 shall contain a physician's order for the enteral nutrition that is medically necessary to treat the diagnosed condition and the recipient's functional limitation. The order for enteral nutrition must be justified in the written documentation either on the DMAS-116 or attached thereto. The DMAS-116 shall be valid for a maximum period of six months. The validity of the DMAS-116 shall terminate when the recipient's medical need for the prescribed enteral nutrition ends or when the enteral nutrition is no longer the primary source of nutrition.

5. A face-to-face nutritional assessment completed by trained clinicians (e.g., physician, physician assistant, nurse practitioner, registered nurse, or a registered dietician) must be completed as required documentation of enteral nutrition for both the initial order and every six months. The DMAS-116 is required every six months.

6. The DMAS-116 shall not be changed, altered, or amended after the physician has signed it. If changes are necessary, as indicated by the recipient's condition, in the ordered enteral nutrition, the DME provider must obtain a new DMAS-116. New DMAS-116s must be signed and dated by the physician within 60 days from the time the ordered enteral nutrition is furnished by the DME provider. The order cannot be back-dated to cover prior dispensing of enteral nutrition. If the order is not signed within 60 days, then the date the order is signed becomes the effective date.

7. Preauthorization of enteral nutrition is not required. The DME provider must assure that there is a valid DMAS-116 completed every six months in accordance with DMAS policy and on file for any Medicaid recipient for whom enteral nutrition is provided. The DME provider is further responsible for assuring that enteral nutrition is provided in accordance with DMAS reimbursement criteria. Upon post payment review, DMAS will deny reimbursement for any enteral nutrition that is not provided and billed in accordance with the criteria described in the AIDS Waiver Services Manual.

8. DMAS shall have the authority to determine that the DMAS-116 be valid for less than six months based on medical documentation submitted.

C. Provider responsibilities.

1. The DME provider must provide the enteral nutrition as prescribed by the physician on the DMAS-116. Orders shall not be changed unless the DME provider obtains a new DMAS-116 prior to ordering or providing the enteral nutrition to the recipient;

2. The physician's order (DMAS-116) must state that the enteral nutrition is the primary source and specify either a brand name of the enteral nutrition being ordered or the category of enteral nutrition which must be provided. If a physician orders a specific brand of enteral nutrition, the DME provider must supply the brand prescribed. The physician order must include the daily caloric order and the route of administration for the enteral nutrition. Supporting documentation may be attached to the DMAS-116 but the entire order must be on the DMAS-116.

3. Enteral nutrition must be furnished exactly as ordered by the physician on the DMAS-116. The DMAS-116 and any supporting verifiable documentation must be complete (signed and dated by the physician) and in the provider's possession within 60 days from the time the ordered enteral nutrition is initially furnished by the DME provider.

4. The DMAS-116 may be completed by the registered nurse, registered dietician, physician, physician assistant, or nurse practitioner, but it must be signed and dated by the physician.

5. The DMAS-116 must be signed and dated by the assessor and the physician within 60 days of the DMAS-116 begin service date. If the DMAS-116 is not signed and dated by the assessor and the physician within 60 days of the DMAS-116 begin service date, the DMAS-116 will not become valid until the date of the physician's signature.

6. The DMAS-116 must include all of the following elements:

- a. Height (or length for pediatric patients);

- b. Weight. For initial assessments, indicate the recipient's weight loss over time;
- c. Formula tolerance (e.g., is the recipient experiencing diarrhea, vomiting, constipation). This element is only required if the recipient is already receiving enteral nutrition;
- d. Indication of whether the enteral nutrition is the primary or sole source of nutrition;
- e. Route of administration;
- f. The daily caloric order and the number of calories per package, can, etc.;
- g. Extent to which the quantity of the enteral nutrition is available through WIC; and
- h. Title, signature, and date of the assessor and the physician.

7. The DME provider shall retain a copy of the DMAS-116 and all supporting verifiable documentation on file for DMAS' post payment review purposes. DME providers shall not create or revise DMAS-116s or supporting documentation for this service after the initiation of the post payment review process. Physicians shall not complete, or sign and date, DMAS-116s once the post payment review has begun.

8. DME providers shall retain copies of the DMAS-116 and all applicable supporting documentation on file for post payment reviews. Enteral nutrition that is not ordered on the DMAS-116 for which reimbursement has been made by Medicaid will be denied. Supporting documentation is allowed to justify the medical need for enteral nutrition. Supporting documentation does not replace the requirement for a properly completed DMAS-116. The dates of the supporting documentation must coincide with the dates of service on the DMAS-116 and the medical practitioner providing the supporting documentation must be identified by name and title. DME providers shall not create or revise DMAS-116s or supporting documentation for enteral nutrition provided after the post payment review has been initiated.

9. To receive reimbursement, the DME provider is expected to:

- a. Deliver only the item(s) ordered by the physician and approved by DMAS or the designated preauthorization contractor;
- b. Deliver only the quantities ordered by the physician and approved by DMAS or the designated preauthorization contractor;
- c. Deliver only the item(s) for the periods of service covered by the physician's order and approved by DMAS or the designated preauthorization contractor;
- d. Maintain a copy of the physician's order and all verifiable supporting documentation for all DME ordered;
- e. Document all supplies provided to a recipient in accordance with the physician's orders. The delivery ticket must document the recipient's name and Medicaid number, the date of delivery, what was delivered, and the quantity delivered.

10. DMAS will deny payment from the DME provider if any of the following occur:

- a. No current, fully completed DMAS-116, appropriately signed and dated by the physician;
- b. Documentation does not verify that the item was provided to the recipient;
- c. Lack of medical documentation, signed by the physician to justify the DME and supplies; or
- d. Item is non-covered or does not meet DMAS criteria for reimbursement.

11. The enteral nutrition vendor must provide the supplies as prescribed by the physician on the DMAS-116. Orders shall not be changed unless the vendor obtains a new DMAS-116 prior to ordering or providing the supplies to the patient.

12. Medicaid shall not provide reimbursement to the medical equipment and supply vendor for services provided prior to the date prescribed by the physician or prior to the date of the delivery or when services are not provided in accordance with published policies and procedures. If reimbursement is denied for one of these reasons, the DME provider may not bill the Medicaid recipient for the service that was provided.

13. The following criteria must be satisfied through the submission of adequate and verifiable documentation satisfactory to the department. Medically necessary DME and supplies shall be:

- a. Ordered by the physician on the DMAS-116;
- b. A reasonable and necessary part of the recipient's treatment plan;
- c. Consistent with the recipient's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the recipient;
- d. Not furnished solely for the convenience, safety, or restraint of the recipient, the family, attending physician, or other practitioner or supplier;
- e. Consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and
- f. Furnished at a safe, effective, and cost-effective level suitable for use in the recipient's home environment.

**12VAC30-120-200. ~~Skilled nursing services.~~ Private duty nursing services.**

These requirements govern the provision of ~~skilled~~ private duty nursing services.

A. General. ~~Skilled~~ Private duty nursing services ~~may~~ shall be offered to ~~individuals~~ recipients enrolled in the ~~with AIDS Waiver /ARC~~ when such services are deemed necessary by the attending physician to avoid institutionalization by ~~assessment~~ assessing and monitoring of the medical condition, providing interventions, and communicating with the physician regarding changes in the ~~patient's~~ recipient's status. The hours of private duty nursing shall be limited by medical necessity ~~and cost effectiveness~~. The purpose of private duty nursing is to provide for ongoing monitoring, continued nursing supervision, and skilled care. This service should not be authorized when intermittent skilled nursing visits could be utilized. Private duty nursing services should not be provided simultaneously with LPN respite care.

B. Special provider participation conditions. To be approved for ~~skilled-private duty~~ nursing contracts with DMAS, the private duty skilled-nursing provider shall:

1. Be a home health agency licensed or certified by the Virginia Department of Health for Medicaid participation and ~~with which DMAS has a signed participation agreement contract~~ for private duty nursing ~~services~~;
2. Demonstrate ~~a~~ prior successful health care delivery.
3. Operate from a business office.
4. Employ (or subcontract with) and directly supervise a registered nurse (~~RN~~) or a licensed practical nurse.
  - a. ~~The registered nurse with a current and valid license issued by the Virginia State Board of Nursing. The RN shall be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or nursing home facility, or as an LPN.~~
  - b. The LPN shall be currently licensed to practice in the Commonwealth.

C. Limits to services.

1. Private duty nursing shall be reimbursed for a maximum of 16 hours within a 24-hour period per household.
2. In no instance, shall the designated preauthorization contractor approve an ongoing plan of care or ongoing multiple plans of care per household that result in approval of more than 16 hours of private duty nursing in a 24-hour period per household.
3. Congregate private duty nursing. When two waiver recipients share a residence, there shall be a maximum ratio of one private duty nurse to two waiver recipients. When three or more waiver recipients share a residence, ratios will be determined by the combined needs of the recipients.

D. Provider reimbursement.

1. All private duty nursing services shall be reimbursed at an hourly rate determined by DMAS.
2. If the AIDS Waiver recipient needs skilled nursing and has another payer (Medicare or private insurance), the skilled nursing must be covered by the other payers first. Whatever skilled nursing services are not covered under the primary insurance, Medicaid may provide coverage. There shall be no duplication of nursing services with other payers or other State Plan services.
3. RN/LPN shall not practice without signed physician orders specifically identifying skilled tasks to be performed for the recipient.
4. The registered nurse shall review the medications and treatments rendered by the LPN every 60 days and verify the physician's orders.

E. Assessment and plan of care requirements.

1. The case manager shall be responsible for ensuring that the assessment, care planning, monitoring, and review activities required by DMAS are accomplished and documented, consistent with DMAS requirements.

2. Development of the plan of care.

a. Upon completion of the required assessments and a determination that the recipient needs substantial and ongoing skilled nursing care, the hours of nursing service required shall be developed and approved by the designated preauthorization contractor.

b. At a minimum, the plan of care shall include:

1. Identification of the type, frequency, and amount of nursing care needed. This shall include the name of the provider agency, whether the nurse is an RN or LPN, and verification that the nurse is licensed to practice in the Commonwealth.

2. Identification of the type, frequency, and amount of care that the family or other informal caregivers shall provide.

F. Patient selection of waiver services.

1. The case manager shall give the legally competent recipient, or the recipient's legal guardian, or the parent of a minor child the choice of waiver services or institutionalization. This choice must be documented.

2. If waiver services are chosen, the applicant or his legally responsible entity will also be given the opportunity to choose the providers of services if more than one provider is available to render the services. This choice must also be documented. If more than one waiver recipient will reside in the home, one waiver provider shall be chosen to provide all private duty nursing services for all waiver recipients in the home. Only one nurse will be authorized to care for every two waiver recipients in a residence. In the instance when more than two waiver participants share a residence, nursing ratios will be determined by the designated preauthorization contractor based on the needs of all the recipients living together.

3. The designated preauthorization contractor and/or DMAS shall review and approve the assessment and plan of care prior to the individual's admission to community waiver services, and prior to Medicaid payment for any services related to the waiver plan of care.

G. Reevaluation requirements and utilization review.

1. The need for reevaluations shall be determined by the case manager, registered nurse, DMAS, or the designated preauthorization contractor. Reevaluations shall be conducted by the (above) as required by the recipient's needs and situation and at any time when a change in the recipient's condition indicates the need for reevaluation.

2. Utilization review shall be conducted by DMAS on all providers to ensure consumer satisfaction, the adherence to state and federal provider qualifications, and documentation requirements. DMAS will also ensure the appropriate billing practices for waiver services.

H. Registered nurse supervisory duties.

1. The registered nurse shall make, at a minimum, a visit every 30 days to the recipient's home to assess the recipient's/caregiver's satisfaction with the services being provided.
2. The registered nurse shall review medications and treatments rendered by the private duty nurse every 60 days and verify orders with the physician signature.
3. The registered nurse shall review all discharge orders written upon the recipient's discharge from the hospital and provide a copy of such to the private duty nurse rendering care to the recipient in his home.
  - a. The RN shall make an initial assessment visit prior to the start of care for any recipient admitted to private duty nursing.
  - b. During visits to the recipient's home, the registered nurse shall observe, evaluate, and document the adequacy and appropriateness of private duty nursing services with regard to the recipient's current functioning status, medical, and social needs. The recipient's or family's satisfaction with the type and amount of service must be discussed. The registered nurse shall document in a summary note:
    - (1) Whether private duty nursing services continue to be appropriate;
    - (2) Whether the plan of care is adequate to meet the recipient's needs or if changes need to be made to the plan of care;
    - (3) The recipient's satisfaction with the service;
    - (4) Any hospitalization or change in the medical condition or functioning status of the recipient; and
    - (5) Other services received and their amount.
- I. Required documentation for recipients' records. The provider agency shall maintain all records of each private duty nursing recipient. These records shall be separate from those of other non-home and community-based care services, such as companion or home health services. These records shall be reviewed periodically by the DMAS staff who are authorized by the agency to review these files during utilization review. At a minimum, the record shall contain:
  1. The most recently updated Long-Term Care Uniform Assessment Instrument (UAI), documentation of any inpatient hospital admissions, the Medicaid-Funded Long-Term Care Service Authorization form (DMAS-96), the Screening Team Service Plan for Medicaid-Funded Long-Term Care (DMAS-97), all Home Health Certification and Plans of Care (CMS-485), Skills Checklist for Private Duty Nursing (DMAS-259), all Patient Information Forms (DMAS-122) and all signed physician's orders.
  2. The initial assessment by the registered nurse completed prior to or on the date services are initiated;
  3. Registered nurses' notes recorded and dated during visits to the recipient's home. The registered nurses' notes shall contain:
    - a. The specific services delivered to the recipient and the recipient's response;

DEPT. OF MEDICAL ASSISTANCE SERVICES

HIV/AIDS Waiver Services

12 VAC 30-120-140 et. seq.

Page 42 of 42

b. Comments or observations about the recipient. Comments shall include but not be limited to observation of the recipient's physical and emotional condition, daily activities, and the recipient's response to the services rendered;

c. The signature by the registered nurse or the licensed practical nurse and the recipient at least once a week to verify that private duty nursing services have been rendered. This record must be maintained in the recipient's record.

4. All correspondence to the recipient, DMAS, and the designated preauthorization contractor;

5. Reassessments made during the provision of services; and

6. Significant contacts made with family, physicians, DMAS, the designated preauthorization contractor, formal and informal service providers and all professionals related to the recipient's Medicaid services or medical care.

7. Copies of all nurses' records shall be subject to review by state and federal Medicaid representatives.

8. If a private duty nursing recipient is also receiving any other service (meals on wheels, companion, home health services, etc.) the nurse record shall indicate that these services are also being received by the recipient.

9. There should be no duplication of nursing services with other State Plan services or payors.

CERTIFIED: I certify that these regulations are full, true, and correctly dated.

12/30/2003  
Date

/s/ P. W. Finnerty  
Patrick W. Finnerty, Director  
Dept. of Medical Assistance Services